TWIN CITIES DENTAL
RELAXED - ADVANCED - AFFORDABLE

NEW PATIENT INFORMATION

FIRST NAME _____ MI _____ LAST NAME _____

ADDRESS _____ CITY _____ ZIP _____

EMAIL ADRRESS _____

□Home PHONE _____-_____-_____ DATE OF BIRTH (*MM/DD/YYYY*) _____-_____-_____

□Cell PHONE _____-_____-_____ AGE_____

MARITAL STATUS (Circle one) Single Married Divorced Widowed Separated

GENDER (Circle one) *Male* *Female* SOCIAL SECURITY # _____-_____-_____

EMERGENCY CONTACT NAME _____ PHONE _____-_____-_____
RELATIONSHIP TO PATIENT _____

INSURANCE INFORMATION

RESPONSIBLE PARTY FIRST NAME _____ LAST NAME_____

RELATIONSHIP TO PATIENT _____ BIRTHDATE _____/_____/_____

SOCIAL SECURITY # or ID _____ GROUP # _____

PHONE # _____-_____-_____ EMPLOYER NAME _____

SECONDARY INSURANCE _____

*LAST DENTAL VISIT _____ REASON FOR VISIT_____
* Date of last functional bite assessment_____

OTHER INFORMATION

HOW DID YOU HEAR ABOUT THE CLINIC? (Circle one)

- *Internet search*
- *Family Member (Name)* _____
- *Friend (Name)* _____
- *Insurance Company*
- *Drive by Clinic*
- *Facebook*
- *Groupon #* _____
- *Event/Expo (Name)* _____
- *10% Employee Plan*
- *Other Advertisement* _____

(Initial)_____The clinic have permission to send text message reminders to the number provided.
(Initial)_____The clinic have permission to send emails to the address provided?

Are you interested in any of the following services? (Circle all that apply)

Teeth Whitening	*Braces*	*Invisalign*
Mouth Guards	*Patient Referral Discounts*	*Cosmetic Dentistry*
Dental Implants	*Crowns*	*Other*

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MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Patient Name: _____ **Birth date**: _____

Are you under the care of a physician now? ( ) Yes ( ) No Have you ever had a serious Head or Neck injury? ( ) Yes ( ) No

Do you use tobacco products? ( ) Yes ( ) No Do you use controlled substances? ( ) Yes ( ) No

Have you ever been hospitalized or had a major operation? ( ) Yes ( ) No_____

Are you taking any medications, pills, and or drugs? (Please list)

_____

_____

Do you require a premedication BEFORE dental treatment? ( ) Yes ( ) No If yes, what do you normally take?_____

Do you take aspirin daily or any other kind of blood thinner? _____

Are you allergic to any of the following?

Aspirin___ Penicillin ___ Codeine___ Acrylic___ Metal___ Latex___ Local Anesthetics___

Other_____

Women:

Are you pregnant? ( ) yes ( ) no If yes when is your estimated due date? _____

Are you nursing? ( ) yes ( ) no Are you taking oral contraceptives? ( ) yes ( ) no (some medications may interfere)

Please read the following list and mark any conditions you HAVE or you have HAD

AIDS/HIV ( )Yes ( ) No
Alzheimer ( )Yes ( ) No
Anaphylaxis ( )Yes ( ) No
Anemia ( )Yes ( ) No
Angina ( )Yes ( ) No
Arthritis/Gout ( )Yes ( ) No
Artificial Heart Valve( )Yes ( ) No
Artificial Joint ( )Yes ( ) No
Asthma ( )Yes ( ) No
Blood Disease ( )Yes ( ) No
Blood Transfusion ( )Yes ( ) No
Breathing Problem( )Yes ( ) No
Bruise Easily ( )Yes ( ) No
Cancer ( )Yes ( ) No
Chemotherapy ( )Yes ( ) No
Chest Pains ( )Yes ( ) No
Cold Sores/Blisters( )Yes ( ) No
Congenital Heart Disorder( )Yes ( ) No
Diabetes ( )Yes ( ) No
Drug Addiction ( )Yes ( )No

Emphysema ( )Yes ( ) No
Epilepsy or Seizures( )Yes ( ) No
Excessive Bleeding ( )Yes ( ) No
Excessive Thirst ( )Yes ( ) No
Fainting Spells/Dizzy ( )Yes ( ) No
Frequent Headaches ( )Yes ( ) No
Glaucoma ( )Yes ( ) No
Heart Attack/Failed( )Yes ( ) No
Heart Murmur ( )Yes ( ) No
Heart Pace Maker ( )Yes ( ) No
Heart Disease ( )Yes ( ) No
Hemophilia ( )Yes ( ) No
Hep A( ) HepB( ) HepC ( )( )No
High Blood Pressure ( )Yes ( ) No
High Cholesterol ( )Yes ( ) No
Hypoglycemia ( )Yes ( ) No
Kidney Problems ( )Yes ( ) No
Stroke ( )Yes( ) No When? ____
Leukemia ( )Yes ( ) No
Liver Disease ( )Yes ( ) No

Low Blood Pressure( )Yes ( ) No
Lung Disease ( )Yes ( ) No
Mitral Valve ( )Yes ( ) No
Osteoporosis ( )Yes ( ) No
Pain in Jaw Joints ( )Yes ( ) No
Psychiatric Care ( )Yes ( ) No
Radiation Treatment( )Y ( ) No
Renal Dialysis ( )Yes ( ) No
Rheumatism ( )Yes ( ) No
Sickle Cell Disease( )Yes ( ) No
Sinus Trouble ( )Yes ( ) No
Stomach/Intestinal Disease( )Yes( ) No
Thyroid Disease ( )Yes ( ) No
Tonsillitis ( )Yes ( ) No
Tuberculosis ( )Yes ( ) No
Tumors ( )Yes ( ) No
Ulcers ( )Yes ( ) No
Yellow Jaundice ( )Yes ( ) No
Do you take Cortisone? _____

Have you ever had any serious illness not listed above? _____

Comments:_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform Twin Cities Dental of any changes in medical status.

Signature of Patient, Parent, or Guardian_____ Date_____

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Policy and Patient Responsibility

Thank you for choosing Twin Cities Dental PA as your dental care provider. We are committed to your treatment being successful. Please understand that prompt payment of your bill is considered part of your treatment. We have put together the details of our credit and financial policies below. Please read carefully and sign below before you begin treatment. All patients must complete our information and insurance forms.

FULL PAYMENT IS DUE AT THE TIME OF SERVCE.

For your convenience we accept cash, Personal Checks or Visa, American Express and Master Card.
We offer payment plans with Care Credit with prior approval and signed agreement.
A finance charge of 18% annually (1.5% per month) will begin accruing 60 days after the date of service.

PATIENTS WITH INSURANCE COVERAGE

We will accept assignment of insurance benefits. However, we do require your co-payment to be paid at the time of service. The balance incurred is your personal responsibility whether your insurance company covers it or not. Coverage amounts vary from policy to policy and we cannot guarantee the amount of coverage offered by your insurance carrier. It is your responsibility to seek coverage amounts and limits of liability on your insurance policy. You understand that you insurance policy is a contract between you and the insurance company. Our office will not be held responsible in the event your insurance company denies any claim.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients. We charge what is usual and customary for our area. You are responsible for your payments regardless of what your insurance company covers.

DELINQUENCY

In the event your account becomes past due and is referred to an outside collection agency or attorneys, you will be responsible for the collection cost up to 33% of the balance due. Along with reasonable attorney fees and court cost incurred by this office.
I have read and understand Twins Cities Dental, PA credit and financial policy with respect to payment on my account.

Signature: _____

Date _____ Name (Print) _____

HIPAA

☐ I certify that I have read and understood the HIPAA Notice of Privacy Document.

Signature: _____ DATE: _____